

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155666</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>05/19/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY HEALTHCARE</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>1751 WESLEY ROAD</b> <b>AUBURN, IN 46706</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to a Recertification and State Licensure Survey completed on April 8, 2011. This visit included the PSR to the Investigation of Complaint number IN00088668 completed on April 8, 2011.</p> <p>Complaint IN00088668-----corrected</p> <p>This visit was done in conjunction with the PSR to the investigation of complaint IN00086735 completed on 3-22-11.</p> <p>Survey dates: May 18, 19, 2011</p> <p>Facility number: 000307 Provider number: 155666 AIM number: 100285660</p> <p>Survey team: Christine Fodrea, RN, TC Rick Blain, RN Sue Brooker, RD</p> <p>Census bed type: SNF/NF: 42 Total: 42</p> <p>Census payor type: Medicare: 6 Medicaid: 29 Other: 7 Total: 42</p> <p>Sample: 7</p> <p>Wesley Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaint number IN00088668.  Quality review completed 5-20-11 Cathy Emswiller RN			{F 000}			